STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. J-03/08-127
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals the decision by the Department of Disabilities, Aging and Independent Living (DAIL) substantiating a report that he neglected a vulnerable adult. The issue is whether the petitioner's actions meet the statutory definitions of neglect.

FINDINGS OF FACT

1. The petitioner is a registered nurse. At the time in question he was employed at a hospital in northeastern Vermont.

2. On September 8, 2007 S.G., a woman in her mid-nineties, was admitted to the hospital with a compression fracture. On her admission chart she was rated as being at the "highest risk" of falling. She was placed in a room across from the petitioner's nursing station.

3. The day that S.G. was admitted, the petitioner began his nursing shift at 3:00 p.m. The petitioner first had contact with S.G. at 3:30 p.m., when he found her

"pleasantly confused" but concerned about pain from her injury. Over the next few hours S.G. got up about five or six times to use a commode next to her bed. Sometimes she rang her call buzzer, other times the petitioner found her sitting on the edge of the bed attempting to use the commode on her own. Each time she needed a walker to ambulate, with the petitioner providing "maximum assistance".

4. S.G.'s son and his wife visited her in the room from 5:00 p.m. to 6:30 p.m., during which time S.G. appeared coherent and comfortable. The petitioner gave her prescribed pain medication (Percocet) shortly after 6:00 p.m.

5. A 6:45 p.m. the petitioner helped S.G. get ready for the night by placing the rails on the upper part of her bed in the upright position and turning on an alarm on her bed that would activate if she attempted to get up. At this time S.G.'s voice had become slurred.

6. Between 6:45 p.m. and 9:30 p.m. the petitioner checked in on S.G. every fifteen minutes to half hour. During this time S.G.'s bed alarm went off three or four times. When he checked on S.G. during this time the petitioner noted she was sleeping fitfully and awaking frequently asking for more pain medication. The petitioner told her he would give her another dose of pain medication at

10:00 p.m. Although he admits it was within his discretion and judgment to have done so, the petitioner did not call the petitioner's doctor to see if the type and/or frequency of the petitioner's pain medication could be changed.

7. At about 9:30 p.m. the petitioner turned off S.G.'s bed alarm because he felt that the alarm was being "over-sensitive". Other than leaving the rails raised on the top portion of S.G.'s bed, the petitioner did not take any other additional action or precaution to ensure S.G.'s safety, and did not advise any other hospital staff that he had turned off her bed alarm.

8. There is no evidence that S.G.'s bed alarm was malfunctioning that night or that any of the hospital's bed alarms had malfunctioned in the past. There is no dispute that immediately after that night the hospital carefully tested all its bed alarms and found that none of them, including the one on S.G.'s bed, were malfunctioning.

9. At 10:00 p.m. the petitioner returned to S.G.'s room to give her another dose of pain medication. S.G. was awake at that time. The petitioner also gave her a dose of Ambien as a sleep aid at that time. He did not turn her bed alarm back on at that time.

10. The petitioner checked on S.G. again at 10:30 p.m. Although she was asleep the petitioner did not turn her bed alarm back on.

11. Shortly after 10:30 there was a commotion on the floor involving the visiting family of another patient in which one family member had to be taken to the hospital's emergency room.

12. Shortly after this incident, at 10:50 the petitioner heard S.G. call out, and then a "crash" in her room. The petitioner rushed into S.G.'s room and found her lying on the floor, conscious but "totally disoriented". The petitioner quickly ran to get help, and when he returned (with "four assists") and was getting S.G. back into bed he noticed an "egg-sized bump" behind her left ear.

13. The petitioner took S.G.'s vital signs and called her doctor. He continued to monitor S.G.'s vital signs (which were not abnormal) until the end of his shift shortly after 11:00 p.m. S.G. remained awake, agitated, and incoherent during this time.

14. Unfortunately, S.G.'s condition worsened later that night. She ultimately died on September 10, two days later, as a result of the head injury she had sustained in her fall.

15. The petitioner has been candid and cooperative with all the various investigations and subsequent professional actions that have occurred since that night. There is no question that he is chastened and contrite. He admits that if he had left S.G.'s bed alarm on that night it would have placed no "onus" on his work load.

16. At the time of the incident the hospital did not have an explicit written policy regarding the use of bed alarms, although it created and instituted one promptly thereafter. There is no question, however, that the hospital's practice at the time, understood by the petitioner, was to use the bed alarms it had installed for all patients who were at substantial risk of falling.

17. On the day she was admitted to the hospital there were no explicit instructions on S.G.'s admission chart regarding the use of a bed alarm. As noted above, however, her admission chart indicated that she was considered to be at the "highest risk" of falling. The petitioner concedes that there was no medical or professional reason for him to have turned off S.G.'s bed alarm. The evidence in this matter is clear that the petitioner fully understood that S.G.'s physician had *implicitly* directed the hospital to use every available precaution to protect S.G. from falling.

ORDER

The Department's decision substantiating neglect is affirmed.

REASONS

The Commissioner of the Department of Disabilities, Aging and Independent Living (DAIL) is required by statute to investigate allegations of abuse, neglect and exploitation of vulnerable adults, and to keep those records that are "substantiated" in a registry under the name of the person who committed the abuse. 33 V.S.A. §§ 6906 and 6911(b). If a report has been substantiated, the person who has been found to have committed abuse may apply to the Human Services Board for relief that the report is not substantiated. 33 V.S.A. § 6906(d).

The statutory purpose of the registry provision is set forth in 33 V.S.A. 6901 as follows:

> The purpose of this chapter is to: protect vulnerable adults whose health and welfare may be adversely affected through abuse, neglect or exploitation; provide a temporary or permanent nurturing and safe environment for vulnerable adults when necessary; and for these purposes to require the reporting of suspected abuse, neglect and exploitation of vulnerable adults and the investigation of such reports and provision of services, when needed; and to intervene in the family or substitute care situation only when necessary to ensure proper care and protection

of a vulnerable adult or to carry out other statutory responsibilities.

The sections of the statute identified by the Department at the hearing in support of its substantiation of neglect provide as follows:

> (7) "Neglect" means purposeful or reckless failure or omission by a caregiver to:
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> (A)(i) provide care or arrange for goods or services necessary to maintain the health or safety of a vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, unless the caregiver is acting pursuant to the wishes of the vulnerable adult or his or her representative. . .
>
> (iii) carry out a plan of care for a vulnerable adult when such failure results in or could reasonably be expected to result in physical or psychological harm or a substantial risk of death to the vulnerable adult, unless the caregiver is acting pursuant to the wishes of the vulnerable adult or his or her representative. . .
>
> (B) Neglect may be repeated conduct or a single incident which has resulted in or could be expected to result in physical or psychological harm, as a result of subdivisions (A)(i), (ii), or (iii) of this subdivision (7).
>
> (8) “Plan of care” includes *but is not limited to,* a duly approved plan of treatment, protocol, individual care plan, rehabilitative plan, plan to address activities of daily living or similar procedure described in the care, treatment or services to be provided to address a vulnerable adult’s physical, psychological or rehabilitative needs.
>
> (Emphasis added.)

The evidence in this case is clear that the petitioner's actions were in deliberate and reckless disregard of what he knew to be necessary and obvious measures to protect S.G.'s safety. Based on the above findings, and in light of the protective purposes of the statutes, it is concluded that the petitioner's actions clearly meet the definitions of neglect found in *both* sections (7)(A) and (B), above.

Under the statutes, the petitioner is still free to request from the Commissioner an *expungement* of his name from the registry (see 33 V.S.A. § 6911[f]) based on his professional record, cooperation and contrition. However, this has no bearing on the facts and law concerning the Department's decision to *substantiate* the report in the first place. For all the above reasons the Department's decision in this regard must be affirmed. 3 V.S.A, § 3091(d), Fair Hearing Rule No. 1000.4D.

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